

Dissemination of Evidence-Based Psychological Treatments for Posttraumatic Stress Disorder in the Veterans Health Administration

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Unlike the post-Vietnam era, effective, specialized treatments for posttraumatic stress disorder (PTSD) now exist, although these treatments have not been widely available in clinical settings. The U.S. Department of Veterans Affairs (VA) is nationally disseminating 2 evidence-based psychotherapies for PTSD throughout the VA health care system. The VA has developed national initiatives to train mental health staff in the delivery of Cognitive Processing Therapy (CPT) and Prolonged Exposure therapy (PE) and has implemented a variety of strategies to promote local implementation. In this article, the authors examine VA's national CPT and PE training initiatives and report initial patient, therapist, and system-level program evaluation results. Key issues, lessons learned, and next steps for maximizing impact and sustainability are also addressed.

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The U.S. Department of Veterans Affairs (VA) operates an internationally recognized network of more than 230 specialized programs for the treatment of posttraumatic stress disorder (PTSD) through its medical centers and clinics within the Veterans Health Administration (VHA), the health care arm of VA. These programs provide a continuum of care from outpatient PTSD specialty care through specialized inpatient units, brief-treatment units, and residential rehabilitation programs around the country. In addition, a number of programs focus on specific needs, including women's programs, military sexual trauma programs, and dual diagnosis (PTSD and substance use disorder) programs. Beyond PTSD care, the VHA includes a comprehensive continuum of specialized mental health services, covering inpatient, residential, and outpatient

settings, as well as integrated mental health services in nonspecialty mental health areas, such as primary care, geriatrics settings, and rehabilitation settings.

Since 2005, VA has been working to transform its mental health care delivery system (Edwards, 2008). As part of this transformation process, guided by the Comprehensive VHA Mental Health Strategic Plan, VA has expanded its mental health care workforce by over 6,000 staff, and now has a total mental health care workforce of over 20,000 staff. The expansion of PTSD care has been one important area of emphasis in this expansion and transformation process. This includes the placement of PTSD clinical teams or PTSD specialists in each medical center to provide specialized outpatient PTSD services, as well as the placement of substance use disorder clinicians in outpatient PTSD programs at each medical center to help address dual diagnosis PTSD and substance use problems. Since 2005, funding for PTSD services has steadily increased, with an additional significant increase planned for Fiscal Year 2010 (October 1, 2009 through September 30, 2010).

REALIZING THE POTENTIAL OF EVIDENCE-BASED PSYCHOTHERAPIES FOR PTSD IN VA

Despite the well-documented effectiveness of evidence-based psychotherapies and their recommendation in numerous practice guidelines and other reports, research has consistently revealed that mental health providers deliver evidence-based psychological treatments at low rates (Goisman, Warshaw, & Keller, 1999; Rosen et al., 2004). A survey by Rosen and colleagues (2004) of mental health clinicians at six VA medical centers, conducted prior to VA's current evidence-based psychotherapy dissemination efforts, found that evidence-based psychotherapies for PTSD were infrequently provided. Research in other public and private service systems have yielded similar results (Jameson, Chambless, & Blank, 2009; van Minnen, Hendriks, & Olff, 2010). Therefore, VA sees a tremendous opportunity to realize the potential of evidence-based psychotherapies and bridge the gap between research and practice so that veterans have access to highly effective treatments for PTSD and other mental health conditions. Therefore, VA has embarked on a major national effort to disseminate evidence-based psychotherapies for PTSD and other mental health conditions throughout the VA health care system, as part of the implementation of the VHA Mental Health Strategic Plan and the transformation of its mental health care delivery system.

There is a special urgency for undertaking the task of nationally disseminating evidence-based psychotherapies for PTSD as the nation is at war. As of the end of the third quarter of Fiscal Year 2009 (June 30, 2009), 25% of veterans who served in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF; the conflicts in Afghanistan and Iraq, respectively) that have

obtained VA health care have been diagnosed with possible PTSD (representing approximately 120,000 OEF and OIF veterans (U.S. Department of Veterans Affairs, 2010)). Veterans Affairs is committed to making the best treatments science has to offer widely available to these returning veterans with PTSD, as well as to veterans of previous conflicts with PTSD so that they can recover and reclaim their lives as soon as possible. Moreover, as PTSD is now increasingly becoming part of the national lexicon, there is growing awareness of the condition and greater recognition of the need for treatment.

Veterans Affairs has two national initiatives now well underway to disseminate Cognitive Processing Therapy (CPT; Resick & Schnicke, 1992) and Prolonged Exposure therapy (PE; Foa, Hembree, & Rothbaum, 2007) for PTSD throughout the VA health care system. These initiatives include national programs to provide intensive, competency-based training to VA mental health providers in the delivery of these therapies. Both CPT and PE have been examined in a number of randomized controlled trials and shown to be effective in similar degree (e.g., Chard, 2005; Foa et al., 2005; Monson et al., 2006; Nacasch et al., in press; Resick et al., 2008; Resick, Nishith, Weaver, Astin, & Feurer, 2002; Schnurr et al., 2007). Although much of this research has focused on nonveteran samples (e.g., nonveteran sexual trauma survivors), there has been increasing research documenting the efficacy and effectiveness of these therapies with veterans (Chard, Schumm, Owens, & Cottingham, 2010; Monson et al., 2006; Nacasch et al., 2007; Nacasch et al., in press; Rauch et al., 2009; Riggs et al., 2003; Schnurr et al., 2007; Tuerk, Yoder, Ruggiero, Gros, & Acierio, 2010). In addition, treatment gains for both CPT and PE have been shown to maintain for over 5 years after treatment (Resick, Williams, Monson, Gradus, & Suvak, 2010). Both CPT and PE are recommended in the VA/Department of Defense (DoD; 2004) Clinical Practice Guideline for PTSD at the highest level, indicating "a strong recommendation that the intervention is always indicated and acceptable."

As of May 31, 2010, VA has provided training to over 2,700 VA mental health staff in the delivery of CPT or PE, and some staff have been trained in the delivery of both therapies. Given the number of VA providers currently trained in CPT or PE and the time requirements needed to deliver these psychotherapies, VHA as a health care system now has the capacity to provide full courses of CPT or PE to all returning OEF and OIF veterans with a primary diagnosis of PTSD who require it within 1 year. VHA is further expanding its cadre of staff trained in evidence-based psychotherapies for PTSD so that OEF and OIF veterans and veterans of all other combat eras have full access to these treatments.

Although clinical training is necessary for nationally disseminating specialized treatments, such as CPT and PE, it is not sufficient. Also required are mechanisms to promote local adoption and implementation. Accordingly, in addition to providing specialized training, the VHA has developed a number of top-down and bottom-up approaches to promote dissemination *and*

implementation.¹ A comprehensive examination of national dissemination and implementation issues, including VA's multilevel model for national dissemination and implementation of evidence-based psychotherapies, is beyond the scope of the present article and is covered elsewhere (Karlin, 2009, 2010). The focus of the present article is on VA's national CPT and PE training initiatives, though key aspects of the dissemination and implementation of CPT and PE, more broadly, are highlighted in the present article. In addition to examining VA's national CPT and PE training programs, this article reports early program evaluation data associated with these initiatives and identifies key issues, lessons learned, and next steps for maximizing impact and sustainability.

One significant top-down mechanism in VHA for promoting dissemination and implementation of CPT and PE—which also illustrates VA's strong commitment to making these treatments widely available—is the recently established VHA policy that all veterans with PTSD have access to CPT or PE. This requirement is included in VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinic* (U.S. Department of Veterans Affairs, 2008). The Handbook defines the full range of mental health services that must be available to all veterans no matter where they receive care. This formal directive represents the culmination of the implementation of the VHA Mental Health Strategic Plan and is designed to complete and sustain the transformation of VA mental health care.

Both CPT and PE are supported in VHA as first-line treatments for those patients with PTSD for whom these therapies are clinically indicated. As such, the dissemination of the therapies is designed to enable medical centers and large clinics to offer all veterans with PTSD who can benefit from these treatments a course of CPT or PE. Many facilities have developed pretherapy processes, such as orientation groups and other mechanisms that provide information about evidence-based psychotherapies and discussion of their potential utility for a particular patient's problems, which allows for veterans' informed choice in the treatment planning process. Ultimately, the selection of treatment is made by the veteran, in consultation with his or her therapist prior to the initiation of care. Moreover, patients may also participate in other treatments and supportive services; often, these are pursued in conjunction with, or immediately prior to, a course of CPT or PE.

A variety of bottom-up approaches have been developed to promote buy-in and support from local staff and leadership. This includes the development of the PTSD National Mentoring program to promote regional and national communication between PTSD clinic managers and sharing of best practices to clinic design

and care processes, including ways of restructuring clinical services to support routine delivery of PE and CPT. In addition, a local Evidence-Based Psychotherapy Coordinator has been appointed at each medical center to serve as a champion for evidence-based psychotherapies at the local level and to promote local implementation of evidence-based psychotherapies. This includes working with mental health and facility leadership to elicit support and the establishment of clinic systems and procedures that enable the delivery of 60-minute, 90-minute, or longer weekly sessions, as CPT and PE require. The PTSD Mentors and local Evidence-Based Psychotherapy Coordinators have been key in developing local clinical infrastructures necessary for the delivery of evidence-based psychotherapies.

VA CPT AND PE DISSEMINATION INITIATIVES

VA initiatives to disseminate CPT and PE in VHA began with the CPT dissemination initiative in 2006. Significantly, VA's dissemination of these two therapies came on the heels of two key studies demonstrating the efficacy of CPT and PE, respectively, with veterans (Monson et al., 2006; Schnurr et al., 2007). These studies provided additional evidence for the use of these therapies with veterans. VA worked expeditiously to develop the CPT dissemination initiative, and soon thereafter, the PE dissemination initiative, immediately after these two studies were completed.

VA's model for training in evidence-based psychotherapies for PTSD consists of two key components: (a) an in-person, experientially based workshop training, followed by (b) ongoing weekly consultation with an expert in the psychotherapy. All participant and staff travel and training costs are funded by the Office of Mental Health Services in the VA Central Office, which oversees the overall dissemination and implementation initiatives. Field-based coordinating sites assist with the day-to-day administration of the training programs.

The selection of participants in each of the training programs is designed to maximize training yield and coverage. Accordingly, priority for training in each of the training programs is on permanent, licensed VHA staff who works with patients with PTSD as a primary or significant job responsibility. Applications are used to assist with the selection process. To participate in the training program, participants agree to complete the workshop training and follow-up case consultation, as well as participate in program evaluation efforts. These criteria are made clear to regional mental health leaders, who help to coordinate a process of nomination for their region. These same criteria are then reiterated to the clinicians whose names are forwarded. Upon selection, participants complete a training application and training agreement, which includes a signature from their supervisor indicating support for their participation and the time commitments involved in participating in training, including ongoing consultation.

¹ The specific references to dissemination *and* implementation are intentional, as these processes are not one and the same. Whereas treatments may be disseminated to providers (using a variety of mechanisms and modalities), they may and often are not *implemented* due to individual provider factors, broader systems or organizational barriers, or other factors.

Specific information about the CPT and PE training programs is provided below, followed by an examination of the initial impact of the training programs and the implementation of the therapies.

VA Cognitive Processing Therapy Training Program

Cognitive Processing Therapy is a 12-session treatment based on a social cognitive theory of PTSD that focuses on the meaning individuals make in response to the traumatic event and how people cope as they try to regain a sense of mastery or control over their lives (Resick & Schnicke, 1992). Cognitive Processing Therapy can be offered as an individual, group, or combined group and individual protocol depending on the needs and resources of the therapy site. Typically, CPT is divided into three phases: education, processing, and challenging. In the first phase, clients are educated about the symptoms of PTSD, the treatment model, and the connection between thoughts and feelings. In addition, they begin to examine how the traumatic events have affected their beliefs about self, others, and the world. In the second phase, clients and therapists take a focused look at the traumatic events through written narratives and/or through Socratic questioning as a way of identifying where the clients have become stuck in their thinking about the event. In the third phase, therapists and clients work together in examining clients' thoughts about the trauma and to create more-balanced beliefs about the trauma means about themselves, others, and the world. A version of CPT, CPT-Cognitive Only (CPT-C), does not include the written narrative component in the treatment. An initial study has shown that CPT-C is as effective as CPT in reducing the symptoms of PTSD (Resick et al., 2008).

The VA CPT dissemination initiative began in the summer of 2006. Leadership from the Office of Mental Health Services and training staff worked closely with Patricia Resick, the original developer of CPT, in the initial development and implementation of the training program. Significantly, the training initiative was initially developed and implemented in a manner that would allow for training a large number of VA mental health providers at a time when most mental health professionals had very little, if any, exposure to still relatively new evidence-based psychotherapies for PTSD. Subsequent quality assurance mechanisms and training resources and requirements (including more structured consultation requirements and additional training, described in more detail below) have been incorporated to promote fidelity, adoption, and implementation of therapy skills among training participants. As of May 31, 2010, VA had provided training in CPT to over 2,300 mental health staff through VA's formal CPT training program and through similar training provided outside of the formal dissemination initiative by CPT training program staff. In addition,

VA has provided training to over 900 mental health clinicians in DoD.

The CPT training program has been implemented in four phases. Phase 1 included the creation of an adapted therapist manual for providing CPT to veterans and active duty service members (Resick, Monson, & Chard, 2008). As part of this adaptation, an introductory section was developed that provides suggestions for addressing client concerns that may be more relevant to a veteran/military population, such as how to reconcile religion and events that occurred in combat. In addition, example worksheets were added that focus on issues associated with combat trauma and military sexual trauma. During this phase, additional key training materials were developed, including PowerPoint presentations for trainers, training videos, consultant and trainer manuals, and a train-the-trainer conference, led by Patricia Resick, Candice Monson, and Kathleen Chard, was held with 15 participants.

Staff training began in Phase II of the initiative, with the first training workshop held in July 2007. Training program staff conducted 22 two-day training conferences in the first year, fully funded and supported by the VA Office of Mental Health Services. Following each of the CPT workshops, weekly consultation calls were provided by master clinicians to training participants. Clinicians who successfully completed the training workshop, actively participated in a minimum of 10 consultation calls, and submitted work samples (redacted session notes from four individual patients or two groups) demonstrating successful application of CPT were deemed to have successfully completed the training program and were provided a certificate of successful completion.

A variety of additional training resources were developed during this phase of the training program, including a VA intranet site with core training materials, extensive supplemental training materials, a discussion board, and other resources. Furthermore, Dr. Resick and other training program staff conducted advanced lectures using video teleconferencing on a variety of topics, including group adaptations, working with patients with comorbid PTSD and substance abuse, and managing challenging cases. Lectures were also audiotaped and posted on the Website. During this phase, a clinician fact sheet and patient brochure were produced to facilitate dissemination by providing a means of educating fellow clinicians and potential patients about CPT.

In Phase III of the initiative, an adapted therapist manual for applying CPT to veterans in group modality was developed (Chard, Resick, Monson, & Kattar, 2008). Related training videos were created and an additional 16 workshops were conducted. Furthermore, during this phase, CPT site consultation was made available to medical centers whereby a CPT trainer or other training program staff visit the facility and help identify effective ways to integrate CPT into programs and services at the site.

Phase IV of the training program, currently underway, has focused on expanding the training, further promoting quality assurance and evaluation, and establishing decentralized training capacity in CPT throughout VHA. In the initial phases of the

CPT training program, semistructured consultation calls with CPT training program consultants were made available as part of the training on a weekly basis to discuss clinical challenges and to problem-solve barriers to implementation. This consultation mechanism was utilized effectively by some clinicians and allowed for broad coverage of consultation resources during the ramp-up phase of the program; however, this semistructured call-in format was not fully utilized by others. Following the ramp-up phase of the training program and the increasing recognition of the value and importance of consultation to successfully learning a specialized psychotherapy, such as CPT, and to its adoption, the consultation component was expanded and made more structured in an effort to promote continuity, cohesion, and depth. The model now consists of required weekly participation in a small-group format over the course of 6 months with an assigned training consultant. Further, the role and centrality of the consultation in the training is made clear to staff and local leadership during the recruitment of training participants. The small-group consultation model has yielded high levels of participation and active engagement among training participants in the consultation.

As a further component of the evolution and expansion of the CPT training program, the workshop training was extended from a 2-day basic training to a 3-day training with a group component. Moreover, for clinicians who did not fully complete the CPT training or required additional training to implement CPT, refresher training and consultation has been added to the program, with the goal of bringing in previously trained clinicians who did not fully complete the training and consultation requirements. In addition to these changes, an extensive, formal evaluation component was recently added to monitor therapist and patient outcomes.

A motivational CPT educational video is also being developed to help clinicians educate patients about CPT and to assist patients in making an informed choice about their care. Also under development is a supplemental online course designed to provide clinicians with a review of the specific elements of CPT in an interactive learning environment with slides, quizzes, and video clips. Clinicians will be able to earn continuing education credits for completing the course, and they can choose to participate in only those sections that they need at a given time. Finally, during the current phase of the dissemination initiative, 4-day train-the-trainer workshops will be provided to selected clinicians who will serve as regional CPT trainers and consultants to broaden dissemination even further and promote sustainability.

VA Prolonged Exposure Therapy Training Program

Prolonged Exposure therapy is a psychotherapy for PTSD that is based on exposure principles and emotional processing theory (Foa & Kozak, 1996; Foa et al., 2007). The first and second sessions focus on psychoeducation that include the rationale for the treatment, a description of its main components, and discussion about

common reactions to traumatic events. Sessions 2 and 3 mark the beginning of in vivo and imaginal exposure, respectively. In vivo exposure is aimed at helping the patient approach objectively safe or low-risk situations they have been avoiding because they do not want to be reminded of the trauma or because they view the world as extremely dangerous. It also contains a behavioral activation component. Imaginal exposure helps the patient revisit the traumatic memories and processing the traumatic experiences through repeatedly retelling the most disturbing events followed by processing the thoughts and feeling they experienced during the imaginal exposure. This repeated retelling and its processing allows the patient to engage in emotions associated with the trauma, to organize the memory, to better differentiate thoughts about the trauma from the traumatic event itself, and to gain mastery of the traumatic memory and PTSD symptoms. Although the PE manual presents a 10-session protocol for PE, there is flexibility within the protocol to address the needs of individual patients. In disseminating PE in the VHA, efforts have been made to expand this flexibility to meet specific needs of the veteran population by modifying the number of sessions to range from 8 to 15. This allows clinicians to address patient variability in the treatment course as some veterans may need fewer or greater numbers of sessions to reach maximal outcomes depending on their symptoms, trauma history, and other factors that may affect their ability to engage in treatment.

The VA PE dissemination initiative began in 2007, shortly after the results of a large VA Cooperative Study (Schnurr et al., 2007) on the efficacy of PE with veterans and active duty military personnel were released. The Office of Mental Health Services and local coordinating site staff at the National Center for PTSD worked closely with Edna Foa, the original developer of PE, and Elizabeth Hembree in the initial development and implementation of the PE training program. As of May 31, 2010, VA has provided training in PE to over 1,100 mental health staff through VA's formal PE training program and through similar training provided outside of the formal dissemination initiative by PE training program staff. In addition, VA has provided training to over 120 mental health providers in the DoD.

The PE training model incorporates three main components that focus on training of clinicians, consultants, and trainers. A key goal of the initiative has been to bring ongoing capacity for sustainable PE training and consultation within the VHA, by training clinicians to implement the treatment and by preparing PE consultants and trainers. During the first 2 years of the initiative, clinician-training workshops were delivered by Edna Foa and Elizabeth Hembree. Thereafter, training has been delivered by approved VA PE trainers. The clinician-training component consists of participation in a 4-day workshop conducted by an approved PE trainer, followed by completion of a minimum of two cases under weekly consultation that included viewing therapy tapes. The initial PE training workshop was conducted in November 2007.

Successful completion of the training program requires completion of the training workshop and consultation on two cases.

In addition to training staff to provide PE, the PE dissemination initiative, from the outset, has placed significant emphasis on building a large capacity of PE consultants and trainers. The consultant group is comprised of clinicians who have received the clinician training, have treated a minimum of two PE cases under consultation, and demonstrated mastery of the PE protocol, and of individuals previously trained under this same model with known mastery of PE. Consultation training also included a 5-day workshop in which a consultant learned which PE components require special attention. Trainers for the 4-day clinician-training workshop are selected based on their performance as consultants and their general mastery of PE. They attend a 3-day trainer workshop and also assist in 4-day clinician-training workshops to gain experience in teaching PE. The focus on developing these three levels of training (providers, consultants, trainers) have allowed the work of Drs. Foa and Hembree to be successfully transferred into the VHA by building a community of PE providers that can receive ongoing support in the implementation of the treatment.

The 4-day clinician-training workshop includes multiple modalities for teaching PE theory and application in a highly experiential manner, incorporating didactic information, video case examples, and role-plays. Workshops begin with an explanation of emotional processing theory, which guides the PE protocol and the evidence for PE's efficacy and effectiveness. This is followed by a discussion of assessment of PTSD to reinforce that patients receiving PE are diagnosed with PTSD and are a good fit for the treatment. Clinician-training participants are then taught the treatment rationale, how to implement in vivo, imaginal exposure, and processing, and how to make procedural modifications when needed. Attention is given to factors unique to veterans and to the implementation of PE in VHA settings. In addition to these training components, efforts are made to dispel common myths about PE and to show the value of the intervention for a range of veteran patients, including Vietnam veterans with chronic PTSD, recent returnees from Iraq and Afghanistan, sexual assault survivors, angry patients, and highly emotional patients. Clinician-training participants discuss how many veterans may be reluctant to seek treatment due to fears of stigma, and how this can be addressed in earlier sessions when motivational work is done. The importance of the therapeutic alliance is also emphasized as this allows for development of trust, which presents a challenge with many veterans. For many, PE may mark the first time they have discussed their trauma in significant detail, making this foundation essential.

Immediately following completion of the workshop, training participants receive weekly consultation, by telephone or face-to-face, as they see their initial PE cases. Consultation takes place in small groups of three or four training participants, supplemented by brief individual consultation sessions. As part of their consultation, training participants send tapes of their sessions to the training consultant, who listens to selected portions of the ses-

sion. In designing the consultation component for this initiative, careful attention has been provided to ensuring an appropriate balance between promoting treatment fidelity and adherence to the PE protocol and addressing real-world implementation issues that characterize large-scale dissemination.

During the training workshop and, especially, the consultation process, significant efforts are made to ensure that training participants understand the emotional processing theory that guides the PE protocol. When clinicians have this core understanding and foundation, they can better explain to patients the purpose and goals of treatment when delivering the treatment rationale. Treatment rationale is particularly salient as it is frequently referenced when clinicians and patients encounter challenging points in treatment.

Rates of participation in the PE training consultation process have been very high. To date, 88% of training participants have completed or are currently actively engaged in the training consultation. Only 12% of training participants have dropped out of the training process prior to full completion of the training, including consultation on two cases. Several factors appear to account for this high rate of involvement. First is the significant emphasis placed on the weekly consultation. The centrality of the consultation is emphasized in every communication with training participants. Training consultants are asked to identify PE cases before they attend the 4-day clinical training workshop, so consultation can commence immediately following the workshop training. Training participants are further asked to initiate treatment with more than one case, to ensure continuity of consultation in the event of treatment dropout. Once consultation has begun, consultees remain with the same consultant throughout the collaborative process and their direct experience makes clear the usefulness of consultation in mastering new therapy skills.

Focused efforts have been placed on selecting high-quality training consultants who demonstrate competence with the PE protocol as well as excellence in communication skills and task reliability. Consultants are selected from ranks of clinician-training participants and then receive a 5-day consultant training. Potential candidates are identified during clinician-training workshops. These initial observations are verified during subsequent consultation sessions. Approximately 25% of trained clinicians are invited to serve as consultants. Funds are provided to facilities to "buy out" 5 hours per week of a clinician's time for serving as a training consultant for the national training initiative. Consultants themselves receive ongoing consultation and support with regard to their consultation performance, via bimonthly telephone calls with the program coordinator, and Drs. Foa and Hembree.

Finally, a range of materials has been developed to support dissemination and delivery of PE. Training materials include consultant and trainer manuals, PowerPoint slide sets designed to systematize the 4-day training workshop, and 7 hours of videotaped skills-training content that is shown during the clinician workshop. Other materials focus on supporting implementation

more broadly. A video designed to increase clinician receptiveness to PE has been produced by Drs. Foa and Hembree, as well as brochures that explain the intervention. Furthermore, a Website intended to support the PE community of practice has been established. Materials under development include a guide for PTSD program directors focusing on how to redesign clinic procedures to facilitate delivery of PE, and a video targeted at motivating patients to participate in PE treatment.

Initial Impact: Early Systems, Patient, and Therapist Outcomes

National multimethod monitoring efforts have been implemented, and additional mechanisms are in development, to track the availability and delivery of evidence-based psychotherapies for PTSD throughout VHA. As part of the initial monitoring efforts, a survey was sent in February 2009, to all VA medical centers to assess CPT and PE treatment availability and capacity in the system partway through the dissemination process. The results of the survey revealed that 96% of facilities were providing CPT or PE; 72% were providing both therapies. Most of the sites that had not yet implemented CPT or PE were working on specific plans for doing so. As a whole, these results indicate significant progress fairly early into VA's dissemination and implementation efforts and are in marked contrast to findings from similar surveys reported in the literature earlier in the decade (Rosen et al., 2004; Russell & Silver, 2007). Additional training and implementation strategies are underway to promote full diffusion and saturation and increase the level of evidence-based psychotherapy capacity throughout the system.

Preliminary results of the program evaluation efforts implemented in the CPT and PE dissemination initiatives suggest significant positive effects on patient and therapist outcomes as a result of the training and implementation of the therapy. Initial program evaluation data reveal an overall average decline of approximately 30% (or 20 points) in PTSD Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993) scores among treatment completers, with similar results for CPT (28%; $N = 93$) and PE (33%; $N = 381$). It is significant to note that these data are effectiveness data from real-world clinical settings, often involving highly complex cases, and reflect therapy outcomes among therapists still in the process of receiving training in CPT and PE. It is also important to note that these outcomes are based on available treatment completer data submitted to date by training participants as part of the initial implementation of program evaluation efforts and do not include outcome data from all training participants. Standardized processes are now in place for evaluating patient outcomes that will yield additional data to supplement these early findings.

In addition to system-level data on implementation and patient outcome data, therapists undergoing training are assessed through surveys on a number of domains related to their experiences with and beliefs toward the therapy prior to training, following comple-

tion of the workshop training, and following consultation. Available survey data from PE training participants further indicate the positive impact of training in a number of domains. (Similar surveys are currently being incorporated into the CPT training program evaluation processes). Specifically, PE training participants were assessed on the degree to which they believed that patients had experienced improvements in overall, occupational, and social functioning on a 7-point Likert scale (1 = *very much worse*, 4 = *neither worse nor improved*, 7 = *very much improved*). Means for protocol completers were higher than those for patients who did not complete the treatment protocol in the areas of improvements in overall functioning, $t(555) = 20.13$, $p < .001$, occupational functioning, $t(509) = 11.22$, $p < .001$, and social functioning, $t(551) = 17.40$, $p < .001$. For patients who completed the treatment protocol, means and standard deviations for clinician-reported improvements in overall, occupational, and social functioning were $M = 6.08$ ($SD = .90$), $M = 5.24$ ($SD = 1.16$), and $M = 5.87$ ($SD = .93$), respectively. For patients who did not complete the treatment protocol, means and standard deviations for these domains were $M = 4.21$ ($SD = 1.16$), $M = 4.06$ ($SD = .89$), and $M = 4.29$ ($SD = 1.03$), respectively.

Clinician self-efficacy to deliver PE and to generate PE referrals were also evaluated at three points in time: pretraining, postworkshop, and postconsultation. Within-subjects repeated measures ANOVA revealed a significant increase in reported self-efficacy to deliver PE from pretraining to postworkshop, $F(1, 188) = 79.50$, $p < .001$, and from postworkshop to postconsultation, $F(1, 188) = 100.67$, $p < .001$, with clinicians expressing increasing confidence in their ability to deliver PE over the course of training. Means and standard deviations for self-efficacy to deliver PE at pretraining, postworkshop, and postconsultation were 5.49 ($SD = .94$), 6.04 ($SD = .58$), and 6.44 ($SD = .50$), respectively, on a 7-point Likert scale (1 = *not at all confident*, 7 = *completely confident*). Similarly, a significant increase in reported ability to obtain patient referrals was observed from pre- to postworkshop training, $F(1, 189) = 27.09$, $p < .001$, and from postworkshop training to postconsultation, $F(1, 189) = 34.17$, $p < .001$, with clinicians expressing greater confidence in obtaining patient referrals over time. Means and standard deviations for confidence in generating PE referrals at pretraining, postworkshop, and postconsultation were 5.12 ($SD = 1.31$), 5.56 ($SD = 1.14$), and 6.02 ($SD = .88$), respectively.

In addition, comparison of training participants' evaluations of the workshop training over time indicates that the quality of clinician training in PE has been sustained during the transition from Drs. Foa and Hembree as workshop trainers to VA trainers. For example, there was no difference in the degree of change in self-efficacy to deliver PE reported following the workshop between participants trained by Drs. Foa and Hembree and those trained by VA trainers, $t(734) = -1.48$, *ns*. Additionally, there was no difference between participants trained by Drs. Foa and Hembree and by VA trainers in the degree to which they felt presenters met

several, specific training objectives with regard to enhancing training participants' knowledge and skill. Specifically, no difference was found on Objective 1—enhance knowledge of empirically supported cognitive-behavioral treatments for PTSD and their comparative efficacy, $t(835) < 1$, *ns*, on Objective 2—learn how to implement treatment components of Prolonged Exposure therapy (PE) for PTSD, $t(834) < 1$, *ns*, or on Objective 3—learn how to modify procedures of PE to manage emotional responses and promote effective emotional engagement, $t(831) = 1.04$, *ns*.

KEY ISSUES AND LESSONS LEARNED

Among the biggest lessons learned from VA's training in CPT and PE to date is the value and importance of ongoing consultation for promoting follow-through of training, skill mastery, and implementation. For both the CPT and PE dissemination initiatives, structured and collaborative consultation on actual cases, led by expert training consultants, appears to promote the development of competencies significantly and more complete and consistent understanding and integration of theory. Moreover, the experience of participating in structured consultation has shown to enhance therapist adoption of the therapy, and the provision of consultation in a fixed, small group format has shown to engender support, collaboration, and group learning and commitment.

One of the most significant initial obstacles to implementing evidence-based psychotherapies for PTSD was the maintenance view of PTSD held by some therapists and patients, suggesting that PTSD is a lifetime disorder and that recovery is not possible. Through focused educational efforts and most significantly, (increasing) word of mouth of significant success with patients to a degree rarely, if ever, seen before, earlier views and perceptions of clinicians have significantly shifted in many cases.

The provision of psychoeducation about the intervention and incorporation of motivational enhancement processes—both at the outset (or prior) to treatment, as well as throughout treatment—has proven especially valuable in promoting veteran participation and interest in evidence-based psychotherapies for PTSD. Most veterans are accustomed to approaches to PTSD that are very different than evidence-based psychotherapies, so discussions about treatment (including both treatment process and outcomes) and the use of nonconfrontational motivational approaches has shown, in many cases, to significantly enhance the therapy experience. This can also be highly valuable for helping to change assumptions patients may have about PTSD and what life may be like following therapy.

Patient testimonials or case descriptions commonly incorporated into CPT and PE have shown to be very useful for promoting discussion and patient motivation for the treatments. Directly learning about how the treatments have been used with veterans and the impact they have had with peers has appeared to significantly increase patient interest in and identification with these therapies. Videos and other materials including patient testimo-

nials and information about peer experiences with CPT and PE have been developed by the CPT and PE training programs and are made available as part of training and through new VA CPT and PE intranet sites.

Furthermore, the focused training application and recruitment process has been a critical component to the dissemination and implementation of CPT. In the initial phases of the CPT training program, training participant eligibility requirements and recruitment processes were not as specifically defined, which contributed to lower rates of training (workshop and consultation) completion. These elements have been formalized and are now incorporated into the CPT and PE training programs (and other VA evidence-based psychotherapy training programs), as are training agreements, which include clear information on the requirements and expectations of the training and the requirement for local leadership approval of staff participation in the workshop and consultation processes. The significant front-end focus on the recruitment and selection of training participants has had a significant, positive impact on the follow-through of training and on adoption, as has the support of regional mental health leaders who have helped facilitate the recruitment and selection processes.

At the beginning of the PE dissemination initiative, there was some expectation that fears of retraumatizing patients might represent a barrier to implementation for some training participants (Becker, Zayfert, & Anderson, 2004). Although concerns of retraumatization are experienced by some clinicians and may in part account for relatively limited use of exposure work in clinical practice, few VA training participants have reported such concerns and the great majority has shown receptivity to the treatment and to the training. It may be that such concerns are lessened when clinicians engage in exposure exercises within the context of receiving expert training and consultation. Qualitative and quantitative information obtained through early program evaluation efforts seem to indicate that this is the case. Furthermore, despite the concerns some clinicians may have about retraumatization, this has been shown to rarely be a significant issue in treatment.

More formidable obstacles to implementation have been related to time constraints. Practitioners are busy, and it can sometimes be challenging to allocate protected time for preparing for sessions and participating in consultation while meeting other work demands. Steps have been taken at a number of local and systems levels to promote training participant and consultant participation, including but not limited to involving local and regional program managers in the initiatives, establishing local and regional level champions and mentors, providing for focused and targeted recruitment of training participants, and explicating the full requirements for and expectations of training in the recruitment process, as well as requiring local leadership approval for staff to participate in the training programs. These changes have yielded success, as have explicit requirements for making CPT and PE available and increasing recognition by medical center leadership of the value of these treatments as they are increasingly used

within VA settings throughout the system. One particularly successful practice for increasing recognition of these treatments is the sharing and presentation of PE and CPT success stories at local staff meetings, seminars, grand rounds, and in local and national periodicals, videos, and podcasts.

Finally, changes to the PTSD treatment culture and adaptation to local clinics and practices have been made to enable the delivery of CPT and PE. For example, a number of clinics have made substantial changes in their orientation from a focus on symptom management strategies to recovery-oriented, protocol-based therapies; maintenance groups for veterans who have completed these therapies or may benefit from adjunctive treatment have also been implemented to consolidate gains and maximize participation in and impact of CPT or PE. Local clinical infrastructure changes have also been made and have been critical to successful local implementation, including scheduling changes to accommodate 90-minute PE sessions and the coordination of combined individual and group CPT delivery. Over the coming year, focused technical assistance will be provided to specific sites that have not yet fully implemented CPT and/or PE.

NEXT STEPS TO MAXIMIZE IMPACT AND SUSTAINABILITY

To solidify, supplement, and expand initial core training, advanced training and supplemental training resources in CPT and PE are being developed. Moreover, training processes and resources are being established to facilitate treatment of symptoms and conditions related to PTSD, such as sleep disturbance. Additional mechanisms for longer-term (posttraining), informal case consultation are also being established.

A next step designed to further broaden dissemination and sustainability of CPT and PE is the development of decentralized training capacity to further broaden dissemination and promote sustainability. To date, VA's dissemination efforts have focused on providing centralized training in an effort to promote rapid dissemination, ensure training quality, and standardize training and therapy procedures. The initial focus on centralized training, with funding and oversight by the Office of Mental Health Services in VA Central Office, has proved to be essential in training a large number of staff, maintaining quality assurance, and promoting local implementation.

To develop decentralized training capacity, trainers and consultants will be trained within each of VHA's 21 Veterans Integrated Service Networks, or regions, that plan, oversee, and coordinate care provided at facilities within that geographical area. These trainers will provide training and consultation to clinicians in their respective networks, provide opportunities to train a broader range of qualified mental health providers (e.g., those that spend a smaller amount of time treating patients with PTSD) than have been the primary focus of the centralized trainings), and pro-

vide training opportunities for mental health trainees (i.e., interns, postdoctoral fellows, and residents). The decentralized training and consultation will be supported by a centralized administrative core and is designed to build training and consultation capacity in evidence-based psychotherapies into corners of the system.

Efforts are also underway to provide training to a number of licensed mental health staff within the Readjustment Counseling Service, at the request of the service. The Readjustment Counseling Service is a parallel system of mental health services in the VHA that works in close coordination with VA medical centers and clinics and focuses on providing readjustment counseling and outreach services to veterans and their families at 232 community-based Vet Centers. Although the focus of the Vet Centers is readjustment counseling, interest among its staff in providing evidence-based psychotherapy for PTSD has increased as patients, who also received CPT or PE services at VA medical centers and clinics, reported and displayed notable therapy gains. In addition, some Vet Center staff members have participated in VA CPT training workshops. Significantly, interest in systematic training in evidence-based psychotherapy for PTSD within the Readjustment Counseling Service was also the result of word of mouth of Vet Center colleagues who had participated in VA training (initially in CPT). Two CPT training cohorts of the Readjustment Counseling Service staff have been established, with these cohorts receiving in-person training and follow-up consultation. As of May 31, 2010, over 120 Vet Center staff had received training in CPT from the VHA. In addition, a training of Vet Center trainers in CPT is planned for September 2010, which is designed to provide training and consultation capacity within the Readjustment Counseling Service. Plans are also being developed for providing training to Vet Center staff in PE.

Plans are also underway to coordinate training in CPT and PE between VA and DoD to ensure that mental health staff in both Departments have access to high-quality training and that broader mechanisms are in place to support and sustain national dissemination and implementation. This collaboration includes the development of shared training resources and strategies, as well as common outcome measures and standards for documentation. This includes the development of an online chat room for VA and DoD mental health clinicians delivering CPT or PE to promote a broad community of CPT and PE providers and provide opportunities for longer-term, informal consultation support.

Finally, an important focus is being placed on promoting clinician self-care and support as thousands of VA therapists are learning and implementing evidence-based, trauma-focused psychotherapies for PTSD. A number of efforts have been developed throughout the system to help prevent clinician burnout and promote a sense of community among clinicians. This includes mechanisms ranging from retreats to peer consultation groups to making available self-care services and resources to staff. National efforts are underway to identify, promote, and disseminate best practices in this area. Furthermore, the online chat portal noted above to be

hosted by the DoD is designed to help establish an online community of VA CPT and PE providers.

CONCLUSION

Thanks to recent science, effective specialized treatments for PTSD, not too long ago considered untreatable, now exist. VA is working with full force to realize the potential of these treatments, investing substantially at multiple levels in making evidence-based psychotherapies for PTSD widely available to veterans who can benefit from them as soon as possible. At the same time, VA has enhanced PTSD screening, identification, and outreach efforts to ensure that as many veterans with PTSD as possible can benefit from these therapies. America's heroes deserve nothing less than the best treatments available, and VA is committed to being the international leader in evidence-based psychotherapy for PTSD.

After more than 3 years since their inception, the initiatives to disseminate and implement CPT and PE have considerably increased the VHA's capacity to deliver these treatments to veterans with PTSD and have significantly enhanced the fidelity with which these treatments are delivered. Perhaps most important, initial program evaluation data are already showing the dissemination of these therapies to have a real impact on the lives of veterans, many of whom have been dealing with PTSD for many years. These early findings are especially significant given that they reflect the clinical experiences of therapists newly trained in these specialized therapies with often highly complex (and chronic) cases and virtually no exclusion criteria. These data also confirm frequent anecdotal reports from clinicians in the field that these therapies have yielded gains they have infrequently (or never) seen in the past with patients with PTSD.

In addition to positive initial impact at the systems and patient levels, available program evaluation data from the PE training program suggest that intensive training has positively impacted therapists' perceived effects of therapy on patients and on their confidence to deliver the therapy. The foregoing findings notwithstanding, it is important to note that the data reported here represent early findings and are limited. Standardized program evaluation processes are in place that will provide additional data that will allow for further conclusions to be drawn.

Lastly, the experience to date have yielded key lessons, which have helped to inform the refinement, maturation, and evolution of VA's CPT and PE dissemination initiatives and next steps designed to maximize dissemination, implementation, and sustainability. The successes, challenges, and lessons learned from these efforts have also helped spawn and inform subsequent initiatives to disseminate evidence-based psychotherapies for depression nationally, serious mental illness, and other mental health and behavioral health conditions in the VHA. Of equal, if not greater signifi-

cance, VA's initiatives to nationally disseminate and implement evidence-based psychotherapies for PTSD may have impact beyond the borders of the VA health care system and help to inform and advance the treatment of PTSD in other private and public mental health care systems.

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